Masha Kogan, DDS

AGREEMENT TO PAY FOR TREATMENT

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

I, THE RESPONSIBLE PARTY LISTED BELOW, HEREBY AGREE TO PAY ALL CHARGES SUBMITTED BY THIS OFFICE DURING THE COURSE OF TREATMENT FOR THE PATIENT.

If the patient is insured with a managed care organization which this office has a contractual agreement with, I agree to pay all applicable deductibles and co-payments, which may arise during the course of treatment for the patient. All co-pays are expected to be paid at the time of service. The responsible party is also required to pay for treatment rendered to the patient, which is not considered to be a covered service by third party insurers.

Missed Appointment Policy - If a patient schedules an appointment and fails to show or cancel the appointment at least 24 hours in advance, they will be considered a "no show" for that visit. Patients will be charged a $75 per hour fee for every missed appointment. This fee is not covered by insurance and is the patients' responsibility. We have created this policy in an effort to be able to see patients in need as quickly as possible.

Returned Check Policy - The return of a check (electronic or paper) issued to the Dental Center of Westport will incur a $45.00 "returned check" fee.

Collection Policy – If we are forced to send a patient to collections for failure to make payment or if a patient declares bankruptcy, they will be expected to pay all charges in advance for any future appointments.

_____ _____

Patient/Guardian Name (Print) Signature

_____

Date

250 Main Street • Westport, CT 06880 • 203-227-8700 • care@dentalcenterwestport.com
www.dentalcenterwestport.com

Masha Kogan, DDS

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

I, the responsible party listed below, hereby authorize this office, including its employees, to release and disclose all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, the responsible party listed below, hereby authorize the release and disclosure of any and all of my child's medical records to any other entity, including, but not limited to specialty hospitals, physicians or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient.

I, the responsible party listed below, hereby authorize the release of any records necessary to assist in the reimbursement of insurance benefits to which I may be entitled.

I, the responsible party listed below, hereby authorize the office and its employees to release medical records which are needed in ordered to provide the patient with the most appropriate medical care.

I, the responsible party listed below, hereby authorize and request the payment of my third party or insurance company benefits be made directly to this office for any services or treatments given to the patient. The signature provided below shall suffice for all insurance forms on a continuing basis.

_____ _____

Patient/Guardian Name (Print) Signature

_____

Date

250 Main Street • Westport, CT 06880 • 203-227-8700 • care@dentalcenterwestport.com
www.dentalcenterwestport.com